the inguinal canal, and the cord tied with separate ligatures on each artery, and one round the whole. The abdominal aperture was then closely sewed with catgut sutures as far down as the edge of the pubic bone. A drainage tube, stitches and Listerian dressings were then applied to the superficial part of the wound.

The patient passed the first week in a precarious state; but subsequently to this improvement set in and on the 20th day meat was allowed and he began to sit up for a short time daily. The deep parts of the wound within the sutures of the inguinal canal healed up by first intention, while the subcutaneous and cutaneous part gaped, and healed by granulation. Thirty-seven days after the operation the patient left for a convalescent hospital having a small sinus which has since gradually closed.—*Brit. Med. Jour.*, Jan. 22, 1887.

XI. **Case of Fæcal Impaction With Complete Obstruction; Relieved by Introduction of Hand After Full Division of Anus.** By PRICE MORRIS, L. R. C. P. The author gives the notes of the case of a young lady aged 24, who first came under his care some years ago complaining of symptoms of indigestion, occasional vomiting, and who on examination was found to have large, nodulated, firm, painless, movable tumors occupying the lower part, and chiefly left side of the abdominal cavity—and whose rectum was so distended from fecal accumulation that a child at full period could easily have passed through it. By diligent use of soaped warm water, and manual exercise, the mass was broken up and removed. For ten months the patient remained well and at the end of that time she again came under the author's care suffering from the same symptoms. The treatment which was of so much service upon the former occasion failed to relieve altogether the obstruction. A mass was left in the sigmoid flexure of the colon which would not descend into the pelvis. Injections were of no avail, owing to the compactness of the mass. Treatment in this direction failing, symptoms of complete obstruction supervened, vomiting followed every meal; and no fecal discharge took place.

The patient subsequently became very emaciated, and death from starvation appeared to be within a measurable distance of time. The

author determined to try the effect of introducing his hand up the rectum. Under chloroform, in order to effect this object he attempted to dilate the anus, but finding this procedure impracticable he divided the whole structures back to the coccyx. The hand then easily passed —a long tube was inserted and warm soaped water was injected; the big mass at the top of the pelvis, was readily grasped with the hand and crushed, and after the arm was withdrawn, the whole of it was expelled. Eventually, the colon was thoroughly explored and cleared of feces. Sutures were then carefully inserted, a soft elastic catheter placed in the bladder, and opium administered. The bowels gradually resumed their normal functions without the use of aperients or enemas, and the patient has remained in this favorable condition for seven years.—*Brit. Med. Jour.*, Dec. 10, 1886.

H. PERCY DUNN (London).

XII. Observations Upon the Operation of Gastrostomy. By Mr. GOLDING BIRD (London). This surgeon having operated upon a patient suffering from epithelioma of the œsophagus, and already extremely weak, with death six hours after, records the following observations:—

The points of interest in the operation were:

1. That after a longitudinal incision below the ribs in the left linea semi-lunaris, the stomach, being contracted and with difficulty drawn down, the part of the stomach sewn into the wound was afterwards seen to be only 2 or 3 inches from the pylorus. This showed what Wilkes and Golding Bird had formerly noticed, *i. e.*, that "the semi-lunar line on the left side appears to be too far to the right in order to open the greater curvature of the stomach, unless at the time of exposing it and drawing it down to the wound in the parietes, it is also drawn over to the right so as to bring the left extremity more into view."

2. That while the stomach wall was held in the wound with blunt forceps it was rapidly and—as the post-mortem examination showed—securely fixed to the incision in the *fascial* structures of the abdominal wall by *continuous* silk suture. The skin was not included, partly to save more time in operating, partly with the hope